DPHHS-AMDD-86
(Rev. 02/14)
Page 1 of 2

STATE OF MONTANA
Department of Public Health and Human Services

LEVEL OF CARE DETERMINATION

Program Requested: Γ Nursing Facility Γ HCBS (Initial) Γ HCBS YES/Discretionary Γ Unknown

Identifying Information

Individual :_____
SSN: _____
Address: _____
City/State/Zip: _____
Phone: _____
D.O.B. _____ Age: _____ Sex: ____
Medicaid Status: _____
Veteran: Γ Yes Γ No
County of Application: _____
Nursing Facility Admit Date: _____
Medicare Skilled? _____ Date _____
Previous Medicaid Screen? _____ Date _____

Date of Request: _____
Anticipated LOS: _____
Screen Request By: _____
Agency: _____ Phone: _____
Individual's Location: _____
Significant Other: _____
Relationship: _____ Phone: _____
Address: _____
City/St/Zip: _____
Other Contacts: _____
_____
_____

Health Care Professional: _____ Phone: _____
Medical Diagnoses/Summary: _____
_____
Special Treatments/Medications/Therapies/Equipment: _____
_____
_____

Social and Other Information: _____
_____
_____

Dementia: Γ Yes Γ No Traumatic Brain Injury: Γ Yes Γ No Communication Deficit: Γ Yes Γ No

Determination

Review Start Date: _____
NF Level of Care: Γ Yes Γ No Level I Date: _____
Temporary Stay: _____ to _____
CPO Technical Assist: Γ CPO Onsite: Γ
Comments: _____
_____
_____
_____
_____
Criteria Met: _____

HCBS Referral: Γ Yes Γ No Date: _____
CMT: _____
NF Placement: _____
Effective Date: _____
Screener: _____ Complete Date:_____
MPQH Contacts: Name and Phone Number
1) _____
2) _____
3) _____
4) _____

cc: Case Management Team _____; Nursing Facility _____; Referral Source _____

RATING SCALE DEFINITIONS:

Follow this scale when completing the Functional Assessment Portion of the Screen.

0 = Independent: The individual is able to fulfill ADL/IADL needs without the regular use of human or mechanical assistance, prompting or supervision.

1 = With Aids/Difficulty: To fulfill ADL/IADL, the individual requires consistent availability of mechanical assistance or the expenditure of undue effort.

2 = With Help: The individual requires consistent human assistance, prompting or supervision, in the absence of which the ADL/IADL cannot be completed. The individual does however actively participate in the completion of the activity.

3 = Unable: The individual cannot meaningfully contribute to the completion of the task.

Follow this scale when completing the Functional Capabilities Portion of the Screen.

0 = Good: Within normal limits.

1 = Mild Impairment: Some loss of functioning, however, loss is correctable and/or loss does not prevent the individual's capacity to meet his/her needs.

2= Significant Impairment: Loss of functioning that prevents the individual from meeting his/her needs.

3 = Total Loss: No reasonable residual capacity.

DPHHS-AMDD-86
(Rev. (02/14)

FUNCTIONAL ASSESSMENT

Name _____

Coding for Functional Assessment: 0 - Independent 1 - With Mechanical Aids 2 - With Human Help 3 - Unable

		Current Status/Service	MPQH USE ONLY Adequat	Comments
	Bathing		Yes No	
	Mobility		Yes No	
	Toileting/ Continence		Yes No	
	Transfers		Yes No	
	Eating		Yes No	
	Grooming		Yes No	
	Environmental Modification		Yes No	
	Medication		Yes No	
	Equipment		Yes No	
	Dressing		Yes No	
	Respite		Yes No	
	Shopping		Yes No	
	Cooking		Yes No	
	Housework		Yes No	
	Laundry		Yes No	
	Money Management		Yes No	
	Telephone		Yes No	
	Transportation		Yes No	
	Socialization/ Leisure Activities		Yes No	
	Ability to Summon Emergency Help		Yes No	

Patient Mental Status: (check all appropriate responses) Oriented: Person Γ Place Γ Time Γ

Coding for Functional Capabilities: 0 - Good 1 - Mild Impairment 2 - Severe Impairment 3 - Total Loss

( ) Occasionally disoriented ( ) Inappropriate Behavior ( ) Medication Misuse ( ) Sleep Problems
( ) Disoriented ( ) Confused ( ) Alcohol/Drug Misuse ( ) Worried/Anxious
( ) Unresponsive ( ) Long Term Memory Loss ( ) Isolation ( ) Loss of Interest
( ) Impaired Judgment ( ) Short Term Memory Loss ( ) Danger to Self/Others 24-Hr Supervision Needed Γ Yes Γ No
( ) Ambulation_____ ( ) Hearing_____ ( ) Speech_____ ( ) Vision_____

Respiratory Status: _____

Comments: _____

_____

_____